

# FUMIGANT EXPOSURE QUESTIONNAIRE

## Fum-Ex1

STUDY SITE (INSTITUTION) \_\_\_\_\_

CO-INVESTIGATOR \_\_\_\_\_

DATE OF EVALUATION \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME-ACRONYM/or Nr. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ (MONTH/DAY/YEAR) or AGE \_\_\_\_ YEARS

SEX F\_\_\_\_ M\_\_\_\_

HEIGHT (cm) \_\_\_\_\_

WEIGHT (kg) \_\_\_\_\_

CURRENT SMOKER: YES \_\_\_\_ NO \_\_\_\_ NEVER SMOKED \_\_\_\_

WHEN DID YOU START SMOKING? DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MONTH/ YEAR)

EX-SMOKER: YES \_\_\_\_ NO \_\_\_\_

DATE QUIT: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MONTH/ YEAR)

SMOKING HISTORY # CIGARETTES \_\_\_\_ per DAY

### OCCUPATIONAL HISTORY

1. JOB DESCRIPTION \_\_\_\_\_

2. SINCE WHEN ARE YOU WORKING IN YOUR CURRENT JOB?

\_\_\_\_ (M)/ \_\_\_\_ (Y)

3. DO YOU HAVE CURRENTLY CONTACT WITH FUMIGANTS, PESTICIDES OR OTHER TOXIC CHEMICALS ?

YES \_\_\_\_ NO \_\_\_\_

4. REGULAR? YES \_\_\_\_ NO \_\_\_\_

5. IF YES TO QUESTION # 3, SPECIFY: \_\_\_\_ Methyl bromide (Bromomethane)

\_\_\_\_ Ethylene dichloride (1,2 Dichloroethane)

\_\_\_\_ Methylene chloride (Dichloroethane)

\_\_\_\_ Phosphine

\_\_\_\_ (OTHER)

\_\_\_\_ (SOLVENTS)

- I. DURATION OF EXPOSURE IN TOTAL \_\_\_\_ (MONTHS)
- II. HOW MANY HOURS DO YOU HAVE CONTACT WITH THE AGENTS MENTIONED ABOVE PER WEEK?  
\_\_\_\_ HOURS
- III. WHEN WAS THE LAST EXPOSURE? \_\_\_\_/\_\_\_\_/\_\_\_\_ (MONTH/DAY/YEAR)
- IV. DURATION OF LAST EXPOSURE \_\_\_\_ (DAYS) \_\_\_\_ (HOURS) \_\_\_\_ (MINUTES)
6. IF NO (QUESTION # 3): DID YOU WORK WITH THESE AGENTS IN THE PAST?  
YES \_\_\_\_ NO \_\_\_\_  
WHICH AGENT? \_\_\_\_\_  
WHAT WAS YOUR JOB DESCRIPTION AT THAT TIME? \_\_\_\_\_  
EXPOSURE STARTED (DATE) \_\_\_\_/\_\_\_\_/\_\_\_\_ (MONTH/YEAR)  
EXPOSURE ENDED (DATE) \_\_\_\_/\_\_\_\_/\_\_\_\_ (MONTH/YEAR)
7. WHILE WORKING DID YOU USE ANY PROTECTION EQUIPMENT? YES \_\_\_\_ NO \_\_\_\_  
IF YES: WHICH? \_\_\_\_\_
8. SYMPTOMS  
HOW MANY TIMES DID THE FOLLOWING SYMPTOMS OCCUR DURING OR AFTER WORK IN THE LAST 12 MONTHS?

SYMPTOMS/INCIDENCE	ALMOST ALWAYS	OFTEN	SPORADIC	ALMOST NEVER	NEVER	WHEN DID IT OCCURE FOR THE FIRST TIME? (M/D/Y)
HEADACHE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
AIRWAYS IRRITATION, COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
MUCOSA IRRITATIONS (EYE ITCHING, RHINITIS, STOMATITIS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
SKIN IRRITATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
NAUSEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
MUSCLE CRAMPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
CONCENTRATION DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
DYSGUSIA Distortion sense of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
NUMBNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
DIARRHEA, ABDOMINAL CRAMPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
WEAKNESS, FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
DISTURBANCE OF MEMORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
CHEST TIGHTNESS, DYSPNEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
EMOTIONAL INSTABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
SLURRED SPEECH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
SLEEP DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
IMPAIRED BALANCE,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

DISTURBED GAIT						
TREMOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. HAVE YOU EXPERIENCED INCREASED COUGH WHILE WORKING? YES ☐ NO ☐

11. HAVE YOU EXPERIENCED INCREASED AIRWAYS IRRITATIONS WHILE WORKING?

YES ☐ NO ☐

12. HAVE YOU EVER BEEN UNCONSCIOUS IN THE LAST YEARS? YES ☐ NO ☐

13. IF YES (QUESTION #10): DID IT HAPPEN AT YOUR WORKPLACE? YES ☐ NO ☐

14. PLEASE INDICATE BELOW WHICH CHRONIC OR ACUTE CONDITION(S) YOU HAVE:

☐ ARTHRITIS, SPECIFY \_\_\_\_\_

☐ RHEUMATIC DISEASE, SPECIFY \_\_\_\_\_

☐ ASTHMA, SPECIFY \_\_\_\_\_

☐ CANCER, SPECIFY \_\_\_\_\_

☐ DIABETES, SPECIFY \_\_\_\_\_

☐ KIDNEY DISEASE, SPECIFY \_\_\_\_\_

☐ LIVER DISEASE, SPECIFY \_\_\_\_\_

☐ OTHER CHRONIC CONDITION, SPECIFY \_\_\_\_\_

15. ARE YOU CURRENTLY TAKING ANY MEDICATION? YES ☐ NO ☐

IF YES, SPECIFY: \_\_\_\_\_

16. DID YOU HAD CONTACT TO GENOTOXIC AGENTS?

YES ☐ NO ☐

WHICH AGENT? \_\_\_\_\_

17. HAVE YOU BEEN EXPOSED TO IONIZING RADIATION FOR DIGNOSTIC PURPOSES?

YES ☐ NO ☐

HOW LONG? \_\_\_\_\_

18. ADDITIONAL INFORMATION IF NEEDED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

THANK YOU VERY MUCH FOR YOUR COOPERATION!